Supreme Court, U. S.
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In The

Supreme Court of the United States

October Term, 1976

No. 76-1580

In the Matter of the Application of

SANDS POINT NURSING HOME,

Petitioner,

-against-

HOLLIS S. INGRAHAM, as Commissioner of Health of the State of New York and RICHARD L. DUNHAM, as Budget Director of the State of New York,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE COURT OF APPEALS OF THE STATE OF NEW YORK

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In The

Supreme Court of the United States

October Term, 1976

No.

In the Matter of the Application of

SANDS POINT NURSING HOME,

Petitioner,

vs.

HOLLIS S. INGRAHAM, as Commissioner of Health of the State of New York and RICHARD L. DUNHAM, as Budget Director of the State of New York,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE COURT OF APPEALS OF THE STATE OF NEW YORK

Petitioner respectfully prays that a writ of certiorari issue to review the final decision of the Court of Appeals of the State of New York, rendered on February 10, 1977, that affirmed the order of the Appellate Division of the Supreme Court of the State of New York, Second Judicial Department, entered on June 23, 1975, which reversed the final judgment of the Supreme Court of the State of New York, County of Nassau, entered on December 14, 1973.

OPINIONS BELOW

The majority decision of the New York State Court of Appeals was not accompanied by any written opinion but referred to the memorandum opinion in the Appellate Division. The memorandum decision by the Court of Appeals and dissent by Justice Fuchsberg is appended hereto, *infra*, at page 1a (not reported). The opinion of the Appellate Division of the Supreme Court referred to in the memorandum decision, is appended hereto, *infra*, at page 2a (48 A.D. 2d 897, 370 N.Y.S. 2d 14). The opinion of the Court of Appeals in *Sigety v. Ingraham* relied upon by the Appellate Division, is appended, *infra*, at page 3a (29 N.Y. 2d 110, 324 N.Y.S. 2d 10, 272 N.E. 2d 524). The opinion of the Supreme Court is appended hereto *infra*, at page 10a (not reported).

JURISDICTION

This petition for certiorari is taken within ninety (90) days of the decision of the Court of Appeals dated and entered February 10, 1977,[1] finally determining the proceeding, pursuant to the requirements of 28 U.S.C. §2101(c). Jurisdiction of this Court is invoked pursuant to 28 U.S.C. §1257(3) on the grounds that respondents have impaired substantial vested property rights of petitioner in violation of the equal protection and due process clauses of the United States Constitution as secured by the Fourteenth Amendment.

QUESTIONS PRESENTED

1. Has petitioner been denied the equal protection of the laws under the Fourteenth Amendment, United States

1. For purposes of this writ the Court of Appeals views a decision affirming an order of the Appellate Division as a final decree since a remittitur is unnecessary to implement the order of the Appellate Division as affirmed. The order of the Appellate Division, is appended, *infra*, at page 8a.

Constitution, where respondent Commissioner departed from his own regulations for calculating petitioner's real property reimbursement for skilled nursing services rendered under the Medicaid Program (42 U.S.C. §1396), by a retroactive application of regulations which did not by their terms require such an application, under circumstances where, of all nursing homes in the State of New York, only petitioner was singled out for such treatment?

2. Has petitioner been denied due process of law under the Fourteenth Amendment, United States Constitution, where petitioner sustains substantial economic losses by reason of respondents' retroactive application of reimbursement regulations, resulting in the disallowance of approved property costs incurred by petitioner as a result of bona fide, arms-length, purchase of the nursing home under circumstances where:

(i) petitioner fully complied with State law requirements that before any sale of a nursing home becomes effective, the approval of respondents must be obtained, based upon a full disclosure of all information required to determine the sufficiency of the anticipated Medicaid reimbursement so as to insure the financial integrity of the venture; and

(ii) State law mandated under penalty of civil and criminal sanctions, that all nursing homes fully participate in the Medicaid Program and without discrimination accept, retain, and provide like care as that available to private patients for all Medicaid qualified patients?

3. May respondents abandon a methodology of Medicaid reimbursement embodied in State regulations which have been submitted to, and approved by, the United States Department of Health, Education and Welfare ("HEW") for inclusion in the New York State Medicaid Plan, pursuant to Social Services Law, Sections 363-a and 364-a(2) and 42 U.S.C. §1396a(a), whenever respondents subjectively determine that a resulting payment for a component element of cost is excessive?

4. Have respondents violated Article 4, Section 8, New York State Constitution by retroactively applying regulations which by their terms did not require such an application?

5. Did respondents' approval of the proposed sale, pursuant to his statutory authority, as acceptable and reimbursable under Medicaid, foreclose the respondent Commissioner from thereafter determining that the fully-disclosed purchase price was excessive and therefore not reimbursable?

CONSTITUTIONAL, STATUTORY AND REGULATORY PROVISIONS INVOLVED

The United States constitutional provision involved is the Fourteenth Amendment.

The federal statutory provisions involved are: 42 U.S.C. §§1396a(a)(1), (5), (8), (13)(E), (30), 1396c.

The State constitutional and statutory provisions involved are: Article 4, Section 8, New York State Constitution; Social Services Law, Sections 363-a(1), 364-a(2); Public Health Law, Sections 12(1), 12-b(2), 206(4)(c), 220, 2801, 2801-a(1), (2), (3), 2802, 2803, 2807, 2904(a), (b).

The State regulatory provisions involved are 10 N.Y.C.R.R. §§86.24, 86.29, 86.32, 620.2, 730.2(g), (1).

These constitutional, statutory and regulatory provisions are set forth *infra* in Appendix II at pages 14a, *et seq.*

STATEMENT OF THE CASE

Petitioner is a State-licensed 130-bed skilled-nursing facility located in Nassau County, New York. The facility was constructed in 1965 and began admitting patients on a voluntary

basis under the Medicaid Program ("Program") in 1966, pursuant to State and federal statutory authorization under Social Services Law, Section 363-a and 42 U.S.C. §1396, *et seq.* At all times herein relevant the overwhelming majority of patients in petitioner's nursing home were eligible Medicaid beneficiaries under the Program. By the adoption in 1970 of amendments to the State's Hospital Code, reported in 10 N.Y.C.R.R. §730.2(g), (1), petitioner and all other skilled-nursing facilities were limited to reimbursement in accordance with Medicaid regulations and required to admit, retain and care for all Medicaid sponsored residents without discrimination. Refusal to comply with such new requirement for mandatory participation in the Program could result in fines and/or criminal penalties under Sections 12(1), 206(4)(c) and 12-b(2) of the Public Health Law.

In New York, reimbursement under the Medicaid Program is administered by the Commissioner of Health, with matching funds amounting to fifty (50%) percent of the costs paid by the United States and the balance shared between the State government and local welfare districts. Detailed reimbursement regulations covering skilled-nursing facilities in the Program were developed by the Hospital Review and Planning Council,[2] with the approval of respondent Commissioner of Health ("Commissioner"). The reimbursement regulations were reported in 10 N.Y.C.R.R. §86, *et seq.* and were submitted to and approved by HEW for inclusion within the New York State Medicaid Plan ("Plan") required by 42 U.S.C. §1396, *et seq.*,[3]

2. A body within the State Health Department ("Department") defined in Sections 2801(5), 2904(a), Public Health Law.

3. The authority to enact such reimbursement regulations subject to the Commissioner's approval is set forth in Section 2803, Public Health Law. Guidelines for such regulations were set forth in Section 2807, Public Health Law and have from time to time been revised, with HEW approval to more closely approximate the goals expressed in Section 2807, Public Health Law, or as otherwise mandated by federal statute or regulations. See Section 364-a(2), Social Services Law and Section 2904(b), Public Health Law.

pursuant to Section 363-a(1) and the limitations of Section 364-a(2) Social Services Law, and Section 2904(b), Public Health Law.

The State of New York has elected to control, through licensure and necessary approvals, the establishment, construction and transfer of all hospitals and nursing homes. To secure approval an applicant, *inter alia*, is required to fully disclose all aspects of the proposed transaction to the Public Health Council[4] pursuant to Section 2801-a, Public Health Law and 10 N.Y.C.R.R. §620.2. The Public Health Council of the Department is required, *inter alia*, to reject any application where "(c) the financial resources of the proposed institution and its sources of future revenues;" were unsatisfactory. In addition, because a sale is included within the definition of construction[5], approval of the Commissioner was also required, and he was obliged to refuse permission under Section 2802(3)(d), Public Health Law, whenever "the adequacy of financial resources and sources of future revenue" were deemed unsatisfactory.

The approved regulations covering Medicaid property cost reimbursement, prior to July 1, 1971 provided for reimbursing a skilled-nursing facility's approved property costs. Prior to July 1, 1971 the Commissioner had, from time to time, refused to approve a proposed sale on the grounds that property costs in the hands of the purchaser would be too high and therefore it would not have been in the public interest to permit Medicaid reimbursement in such cases. The approval received by the petitioner in the case at bar, however, effectuated the elimination of the condition precedent to the assumption by petitioner of substantial liabilities.

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4. A planning body defined in Section 220, Public Health Law which is an agency of the Department.

5. Public Health Law, Section 2801(4).

On October 6, 1970, after participation in the Program had become obligatory, petitioner entered into a contract with the former owners of the facility, to purchase the property of the nursing home, *conditioned* on the approval of all governmental agencies having jurisdiction. Respondents have never contested the fact that the negotiations were in all respects bona fide and that the agreement reached was at arms-length between unrelated parties. Petitioner made a full disclosure of all the terms and conditions of the proposed sale and its financing to respondents and indicated that the source of payment relied upon to cover the mortgage commitments and a return on equity would be primarily through Medicaid and to a much lesser extent through private patients paying their proportionate share of such costs. Final approvals were secured from the Commissioner and the Public Health Council on June 7, 1971, which approvals triggered the finality of the contract of sale, by rendering it unconditional. On June 28, 1971, title closed, effective June 30, 1971. As a result petitioner became liable and subject to mortgages totalling $1,700,000 in addition to its substantial cash expenditure on closing.

On August 17, 1971, new State reimbursement regulations were adopted made effective as of July 1, 1971 and were thereafter published pursuant to the requirements of Article 4, Section 8, New York State Constitution. By their terms the regulations were to have prospective application and allowed the Commissioner to determine property cost reimbursement by reference to principles applicable to the Medicare Program under Title XVIII, Social Security Act, 42 U.S.C. §1395, *et seq.* These new regulations were subsequently approved by HEW as part of the Plan. Instead of applying such new regulations prospectively, as called for by the language thereof, and as required by Article 4, Section 8, New York State Constitution, the Commissioner retroactively applied the principles of Medicare property cost reimbursement in computing petitioner's property cost reimbursement, (which had become fixed as of the date of closing of title, June 28, 1971). As a result the

overwhelming portion of approximately $115,100 of annual property costs attributable to Medicaid, or approximately $2.43 per Medicaid patient day was denied to petitioner. This was contrary to the applicable State regulations, incorporated in the Plan with HEW approval, as well as the provisions of Article 4, Section 8 of the New York State Constitution and the requirements of Social Services Law §364-a(2) that the Plan be followed. In addition, the action ran counter to the approval by the Commissioner and the Public Health Council that the cost of purchase was reimbursable under Medicaid and was contrary to the natural expectations and reliance placed by petitioner in such approvals and in the regulations governing reimbursement. Of all persons who had purchased facilities in a fully disclosed, approved, bona fide, arms-length transaction, prior to July 1, 1970, only petitioner was so singled out to be denied reimbursement under the regulations in effect at the time the sale was consummated. Such denial occurred through a retroactive application of regulations or principles embodied therein, adversely affecting substantial interest in property and reimbursement under the compulsory State system of Medicaid participation.

FEDERAL ISSUES RAISED IN THE STATE COURTS

The contention of petitioner that it was denied the equal protection of the laws secured by the Fourteenth Amendment to the United States Constitution was asserted in the New York State Supreme Court through a reference in the pleadings and in a supporting affidavit to unconstitutional actions together with a detailed briefing of the issue. This issue was again presented in briefs submitted to both the Appellate Division and the Court of Appeals. Specific references and quotes are set forth in Appendix III to the petition appearing at pages 31a, *et seq.*

The contention of petitioner that its property has been taken through an unconstitutional, retroactive application of law, which adversely impacted its substantial property rights,

was first briefed in the Court of Appeals, as a result of the Appellate Division's reversal of the Supreme Court. Specific references and quotes are contained in Appendix III to this petition appearing at pages 32a, *et seq.*

The respondents did not contest the factual statements or reply to the constitutional issues asserted, but placed their reliance on Section 2807 of the Public Health Law. Respondents urged that the Commissioner had broad discretion to depart from applicable and controlling reimbursement regulations on an individual basis (despite the Commissioner's role in the "establishment" and approval of the costs) by reason of Section 2807, and the decision of the Court of Appeals in *Sigety v. Ingraham*, 29 N.Y. 2d 110, 324 N.Y.S. 2d 10, 272 N.E. 2d 524.

Petitioner's reply brief pointed out that the *Sigety* decision related to a period in time that preceded the requirement for compulsory participation in the Program, and further that in *Sigety*, the facility unsuccessfully sought to avoid application of regulations published prospectively, while petitioner herein seeks to be governed by the regulations as published and in existence at the time the costs were fixed. The majority of the Court of Appeals affirmed on the opinion of the Appellate Division, failing to discuss any of the complicated issues raised. The dissent in the Court of Appeals fully supported petitioner's contention that its constitutional rights were being abridged.

REASONS FOR GRANTING THE WRIT

It is petitioner's position that:

(1) Petitioner was a bona fide arms-length purchaser of a facility, which became obligated in good faith to pay long term fixed mortgage agreements only after the respondent Commissioner and the Public Health Council gave their approval to such purchase, which approval included a finding that the anticipated reimbursement would be sufficient to pay

such fixed obligations to assure the financial viability of the facility; and

(2) Petitioner is required by State law to render Medicaid services and by reason of the circumstances herein such services must be rendered at less than cost; and

(3) The respondents refused to apply the applicable State reimbursement regulations approved by HEW as part of the State Plan; and

(4) The application of regulations to petitioner was on a retroactive basis; and

(5) The aforesaid action of the respondents was applied solely and exclusively to petitioner; and

(6) Petitioner relied upon the aforesaid approval and the law and regulations applicable to it.

By reason thereof respondents' action:

(a) constituted a denial of "equal protection of the laws" and is a taking of property without due process in violation of the Fourteenth Amendment of the Constitution of the United States, which warrants and permits the issuance of a writ, and further

(b) constituted an abandonment of the principles of Medicaid reimbursement approved by HEW as part of the State Plan in failing faithfully to administer the State Plan, 50% of the cost of which is paid by the United States, is contrary to the intent of Congress expressed in 42 U.S.C. §1396a and §1396c, as well as Section 364-a(2) of the New York State Social Services Law; and

(c) constituted a violation of Article 4, Section 8, New York State Constitution, mandating prospective enforcement of published regulations which by their terms are not retroactive, and further constituted a reversal of respondents' approval of the transaction in accordance with then existing law and regulation, upon which approval, law, and regulation petitioner was entitled to rely, and substituting therefor a new reimbursement mechanism upon a retroactive basis.

Apart from the aforementioned deprivation of personal, constitutionally protected rights, which warrant by themselves the grant of the writ, the questions presented are of significant public interest. The State's highest court has concluded that the Commissioner of Health is not obliged to follow regulations contained in an approved Plan and, accordingly, providers of medical services cannot hope to secure relief in the State courts under the rule of this case whenever the Commissioner "believes" it appropriate to depart from the federally approved Plan which specifies the controlling reimbursement regulations. Providers also cannot look to assistance from HEW under 42 U.S.C. §1396c, since the only remedy available thereunder is the withholding of the fifty (50%) percent federal share of Medicaid costs, which would be destructive of the public health and welfare. To put it mildly, HEW is loathe to take such drastic action. Nor may federal courts offer a satisfactory avenue of relief. Since the holding of this Court in *Edelman v. Jordan*, 1974, 415 U.S. 651, 39 L. Ed. 2d 662, 96 S. Ct. 1347, *reh. denied*, 416 U.S. 1000, 40 L. Ed. 2d 777, 94 S. Ct. 2414, only prospective relief is available in a federal court whenever the State decides to assert its Eleventh Amendment privilege under the Constitution of the United States. By reason thereof, federal courts may not order the payment of reimbursement for past years under the Medicaid Program. Further, because of the enactment by Congress of 42 U.S.C. §1396a(a)(13)(E) effective July 1, 1976 the vast majority of States are in the process of converting from fixed fee Medicaid reimbursement for skilled nursing facility services to reasonable cost related reimbursement

systems. The New York State regulatory system for Medicaid and rulings of its highest court with respect thereto, one of the few states that has had long experience with a cost related reimbursement system, may be expected to be given great weight by other States in implementing their Medicaid Programs. If the unlimited latitude accorded to respondents by the New York Court of Appeals to depart from controlling rules and regulations governing the specifics of reimbursement is permitted to stand unchallenged, such determination will work contrary to the congressional intent set forth in 42 U.S.C. §§1396a(a)(1), (5), (8), (13) (E), (30) and 1396c, mandating the States to honor their approved Plans until they are lawfully changed. In addition, the determination may well prove destructive of the entire Program if private investors, and institutional lenders, perceive that their long term investments in single-purpose facilities may be jeopardized by administrative departures from controlling rules and regulations respecting reimbursement of long term fixed property costs. Predictability in economic affairs is the keystone of a sound financial system.

Petitioner submits that this Court's holding in *Arizona Grocery Co. v. Atchison, Topeka & Santa Fe Ry. Co.*, (1932), 284 U.S. 307, 389, 76 L. Ed. 348, 356, 53 S. Ct. 183, warrants a reversal of the Court of Appeals. In *Arizona,* the Interstate Commerce Commission sought to disregard its own rate regulations, which it later realized provided for an unreasonably high charge. This Court said:

> ". . .it was bound to recognize the validity of the rule of conduct prescribed by it and not to repeal its own enactment with retroactive effect. It could repeal the order as it affected future action, and substitute a new rule of conduct as often as occasion might require, but this was obviously the limit of its power, as that of the legislature itself."

Since this Court has not previously addressed itself to the broad and vital question of Medicaid reimbursement to skilled nursing facilities, the issues presented are significant with respect to the Medicaid Program, the availability of care to the categorically and medically needy as mandated by Congress, 42 U.S.C. §1396a(a)(8), and their impact upon the petitioner, this case presents an appropriate matter for the issuance of a writ of certiorari.

CONCLUSION

The petition for a writ of certiorari should be granted.

s/ Stanley H. Lowell

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APPENDIX I

OPINION OF COURT OF APPEALS (_ N.Y. _ , NOT REPORTED AS YET)

Decided February 10, 1977

Order affirmed, with costs, on the memorandum at the Appellate Division (48 A D 2d 897). All concur except Fuchsberg, J., who dissents and votes to reverse in an opinion.

FUCHSBERG, J (dissenting):

I believe the order of the Appellate Division should be reversed and the judgment of the Supreme Court reinstated.

It is conceded that the petitioner's conditional purchase agreement was not finalized until the purchase price was expressly approved as a basis for property cost reimbursement by the Public Health Council and other appropriate authorized bodies of the Department of Health. The parties are also in agreement that the price arrived at between the seller and the petitioner was not only the true one but was the product of *bona fide*, arms-length negotiations. As such, the basis it provided for reimbursement was in accordance with both the regulations and the practice long and, until then, invariably enforced by the respondent. The Commissioner of Health's later promulgation and application of a new methodology at a time when the petitioner's assumption of his contract obligations had become irreversibly fixed was calculated to and did bring about an impermissible *ex post facto* impairing of substantial vested property rights (cf. *Lynch v. United States*, 292 US 571, 577, 579; *Matter of Bayswater v. Karaghuezoff*, 37 NY 2d 408). Under the circumstances, whatever the warrant for the Commissioner's application of the newly-adopted regulations to transactions not yet approved, it was unlawful for him to apply them retroactively to the one before us.

OPINION OF APPELLATE DIVISION (48 A.D. 2d 897)

MEMORANDUM BY THE COURT.

In a proceeding pursuant to CPLR article 78 *inter alia* for a declaration that a certain regulation is void and to review a determination fixing petitioner's Medicaid reimbursement rate, the appeal is from a judgment of the Supreme Court, Nassau County, entered December 14, 1973, which granted the petition to the extent that it (1) adjudged that appellants' application of 10 NYCRR 86.32 was arbitrary and capricious and that the standard to be applied must be announced in advance, (2) determined that petitioner is entitled to the same method of rate reimbursement that was in existence on the date of its purchase of the facility and (3) referred the matter to appellants to recalculate the costs for the year 1971 and the years thereafter.

Judgment reversed, on the law, with $20 costs and disbursements, determination confirmed, and petition dismissed on the merits.

The subject nursing home was built in 1965 at a cost of $765,269. In 1971 the facility (including land) was sold to its present owner for $2,145,000.

In our opinion, the Medicaid reimbursement rate thereafter fixed by the appellant State Commissioner of Health for the new owner's property cost factor was authorized and consistent with the mandate of subdivision 3 of section 2807 of the Public Health Law, which provides that rates be "reasonably related to the costs of efficient production of such service." That determination was reasonable, was authorized by statute, and should not be disturbed (Matter of Sigety v. Ingraham, 29 N.Y.2d 110, 324 N.Y.S.2d 10, 272 N.E.2d 524).

SIGETY V. INGRAHAM (29 N.Y. 2d 110)

JASEN, Judge.

At issue on this appeal is the validity of the action of the State Commissioner of Health in limiting Medicaid reimbursement rates paid to proprietary nursing homes for services rendered to publicly assisted patients.

Section 2807 (subd. 3) of the Public Health Law, Consol. Laws, c. 45, empowers the Commissioner of Health to certify to the Superintendent of Insurance and the State Director of the Budget that the proposed rate schedules for the nursing homes are reasonably related to the cost of producing such services.[1] Pursuant to this authority, the Commissioner enacted regulations which required the nursing home rates to be individually determined, which limited the rates to 50% of the weighted average adjusted in-patient cost at proprietary hospitals in the State, and which provided a procedure to request a modification of the rates if warranted by a change in economic status. (10 NYCRR 770.2[b], [h] [2], [m], [since repealed].)

Petitioner, who owns and operates the Florence Nightingale Nursing Home, located in the Upper East Side in Manhattan, commenced this proceeding to review a determination of the Commissioner limiting Medicaid reimbursement for nursing home services rendered to publicly assisted patients. The Commissioner originally established petitioner's reimbursement rate to be $21 per day, effective January 8, 1968, and increased this amount to $24 per day on September 30, 1968. Petitioner made no attempt to seek judicial review of these determinations. As a consequence of section 770.2([h][2]), the Commissioner

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1. This law was amended as of May 26, 1969, to specify some of the elements of cost to be taken into consideration in setting these rates and to require that they be reasonably related to the *efficient production* of such services.

determined the weighted average adjusted in-patient daily cost at proprietary hospitals to be $58 per day.[2] Thus, the maximum reimbursement rate for publicly assisted patients at proprietary nursing homes for the 1968-69 period was limited to $29.[3]

Thereafter, petitioner commenced this proceeding on June 26, 1969, contending that his costs exceeded the rates fixed by the Commissioner, and, thus, respondents' actions in limiting his reimbursement rate to 50% of the daily average cost in proprietary hospitals was arbitrary and capricious. Special Term found the rule to be a reasonable and valid exercise of the Commissioner's discretion and dismissed the petition herein. On appeal, the Appellate Division, one Justice dissenting, reversed, 34 A.D.2d 316, 311 N.Y.S.2d 678. The court was of the opinion that the Commissioner's actions "in failing to comply with the statutory directive" (Public Health Law, §2807, subd. 3) that the "rates shall be individually determined, * * * amounted to the assumption of powers in excess of those conferred upon it by law." Justice McNally, in his dissent, stated that the Commissioner could set a maximum reimbursement rate in light of his experience that efficiently operated nursing homes do not exceed the fixed rate. We are in agreement with the dissent below and conclude that the order should, therefore, be reversed and the petition dismissed.

Initially, it should be noted that contrary to the views expressed by the majority below, there is no statutory requirement that the reimbursement rates be individually determined. The statute (Public Health Law, §2807, subd. 3, then in effect) only required that the Commissioner certify that

2. Petitioner makes no challenge to this determination.

3. Accordingly, petitioner's previous reimbursement rate of $24 was increased to the statutory maximum effective April 1, 1969.

the rate schedules "are reasonably related to the costs of providing such service." The only requirement that this reasonably related cost be individually determined is the Commissioner's own rule (§770.2[b]). However, the Commissioner has also determined (§770.2[h][2]) that when these costs exceed 50% of the average daily cost of proprietary hospital care, the rates are not reasonable and, consequently, there will be no individual determination. Thus, there is no inherent conflict between this latter regulation and the statute. Neither is there any inherent conflict between the two regulations. They may be read together to require that rates be individually determined unless they exceed this 50% guideline.

Consequently, the crucial question presented is whether the regulation limiting the reimbursement rates is a reasonable exercise of the Commissioner's authority granted under section 2807 (subd. 3) of the Public Health Law. His determination arrived at by a broad application of specific statutory terms is not to be disturbed if it has a reasonable basis and is not arbitrary or capricious. (Matter of Park East Land Corp. v. Finkelstein, 299 N.Y. 70, 75, 85 N.E.2d 869, 872; see Matter of Fink v. Cole, 1 N.Y.2d 48, 53, 150 N.Y.S.2d 175, 178, 133 N.E.2d 691, 693.) Moreover, where a regulation is not inconsistent with a statute and does not exceed it, the Commissioner's interpretation of the regulation will be controlling and will not be disturbed in the absence of weighty reasons. (Matter of Luxemberg v. Stichman, 2 A.D.2d 605, 607, 157 N.Y.S.2d 395, 397; Lightbody v. Russell, 293 N.Y. 492, 496, 58 N.E.2d 508, 510.) An application of these principles to the facts of this case mandates the conclusion that the Commissioner's actions were eminently reasonable.

What the Commissioner has done is to place a ceiling on nursing home costs. He has found, through his experience, that efficiently run nursing homes will have costs below the

regulatory 50% standard that he has promulgated. The petitioner does not challenge this standard or the assumption (based on the Commissioner's experience) upon which it is founded, but states, however, that his costs are in excess of this amount. Hence, the State *must* reimburse him — no matter how high these cost figures are.

We cannot accept this argument. The Commissioner has, it seems, made a reasonable and laudable interpretation of the statute so as to not reimburse outlandish costs. The statute itself only requires that the rates be *reasonably* related to the costs of such services. Thus, it seems implicit in this statute that the costs be reasonable ones.[4] Since there is no contention the 50% standard is erroneous, the Commissioner's determination should stand.

It seems abundantly clear that the problem presented on this appeal is precisely the situation which the Commissioner is trying to combat. Assuming that petitioner's operation is efficient, the reason for its higher costs is more than likely because it chose to locate in the high-rent upper east side district. There is nothing in the statute to require a full reimbursement because of petitioner's predilections for a fashionable neighborhood.

We have on previous occasions approved a standard announced in advance as an aid in the sound administration of a public power. For instance, in Matter of Old Republic Life Ins. Co. v. Wikler, 9 N.Y.2d 524, 215 N.Y.S.2d 481, 175 N.E.2d 147, the Superintendent of Insurance promulgated certain standard insurance rates pursuant to a statutory power to disapprove

4. We also note that the Commissioner's interpretation of the statute has been explicitly approved by the 1969 amendment thereto which requires that the rates be related to the costs of the *efficient production* of these services.

rates as unreasonable. That action, which we approved, is analogous to the situation here. The Commissioner of Health has simply announced in advance that certain cost figures will be rejected as unreasonable. Consequently, a clear guideline has been established upon which petitioner or others similarly situated may base their cost structures.

It should be emphasized that there is no taking of property involved here. At issue here are Medicaid reimbursement rates for publicly assisted patients placed in a private profit-seeking nursing home. The rates charged to privately supported patients are not affected. Nor is there any requirement that petitioner accept Medicaid patients at these previously announced rates. If petitioner cannot realize a profit at these rates, he has the choice of either making his operation more efficient or not accepting Medicaid patients. The possible fact that the Commissioner's rule adversely affects petitioner's business is no ground for declaring such rule invalid or unreasonable. (Ringling Bros.-Barnum & Bailey Combined Shows, Inc. v. Department of Labor, 18 Misc.2d 1070, 182 N.Y.S.2d 570.)

Petitioner's reliance upon Catholic Med. Center v. Rockefeller, D.C., 305 F.Supp. 1268, aff'd. 2 Cir., 430 F.2d 1297, app. dsmd. 400 U.S. 931, 91 S.Ct. 246, 27 L.Ed.2d 262, is misplaced. The *Catholic Medical Center* case invalidated portions of the 1969 amendment to section 2807 of the Public Health Law which, in effect, placed a freeze upon reimbursement rates given to private hospitals at mid-1969 levels. These provisions were held invalid because of a conflict with provisions in the Social Security Act requiring full reimbursement to these hospitals for their costs. However, the trial court holding therein specifically stated that it would not prevent New York from taking steps to assure that the payments are not in excess of reasonable costs in efficiently run hospitals. (305 F.Supp., at p. 1271.) Thus, this holding would not prevent payments based upon the Commissioner's unchallenged finding

that efficiently run nursing homes have costs below the 50% standard set by him.

Accordingly, the order of the Appellate Division should be reversed and the petition dismissed.

BURKE, SCILEPPI, BERGAN and BREITEL, JJ., concur with JASEN, J.

FULD, C. J., and GIBSON, J., dissent and vote to affirm on the opinion at the Appellate Division.

Order reversed, with costs, and petition dismissed.

APPELLATE DIVISION ORDER

At a Term of the Appellate Division of the Supreme Court of the State of New York, Second Judicial Department, held in Kings County on June 23, 1975.

HON. M. HENRY MARTUSCELLO, Acting Presiding Justice,

HON. HENRY J. LATHAM

HON. JOHN P. COHALAN, JR.

HON. MARCUS G. CHRIST

HON. FRED J. MUNDER *Associate Justices*

In the Matter of Sands Point Nursing Home,

Respondent,

v.

Hollis S. Ingraham, as Commissioner of Health of the State of New York, and Richard L. Dunham, as Budget Director of the State of New York,

Appellants.

Order on Appeal from Judgment

In the above entitled cause pursuant to CPLR article 78 *inter alia* for a declaration that a certain regulation is void and to review a determination fixing petitioner's Medicaid reimbursement rate, the above named Hollis S. Ingraham, as Commissioner of Health of the State of New York, and Richard L. Dunham, as Budget Director of the State of New York, respondents in the court below, having appealed to this court from a judgment of the Supreme Court, Nassau County, entered December 14, 1973, which granted the petition to the extent that it (1) adjudged that appellants' application of 10 NYCRR 86.32 was arbitrary and capricious and that the standard to be applied must be announced in advance, (2) determined that petitioner is entitled to the same method of rate reimbursement that was in existence on the date of its purchase of the facility and (3) referred the matter to appellants to recalculate the costs for the year 1971 and the years thereafter; and the said appeal having been argued by Amy Juviler, Esq., of counsel for the appellants and argued by Stanley H. Lowell, Esq., of counsel for the respondent, due deliberation having been had thereon; and upon this court's opinion and decision slip heretofore filed and made a part hereof, it is

ORDERED that the judgment appealed from is hereby unanimously reversed, on the law, with $20 costs and disbursement, determination confirmed, and petition dismissed on the merits.

Enter:

s/ Irving N. Selkin
Clerk of the Appellate Division

OPINION OF SUPREME COURT (NOT REPORTED)

ROBERT C. MEADE, J.

Petition for a declaratory judgment with reference to the applicability of 10 NYCRR 86.32 of the Official Rules and Regulations is granted to the extent noted herein.

It is undisputed that the petitioner, an existing private proprietary nursing home, was in existence and in operation when the present partnership contracted to purchase it from the previous owners. That contract of purchase was conditioned upon its approval by the Public Health Council of the New York State Department of Health. By letter dated June 7, 1971 (see Ex. B attached to the moving papers) such approval was given. The sale was finalized and the new owners became obligated to the terms of that sale including the cash expenditure of $445,000 and the obligation of two mortgages totalling $1,700,000. As a necessary adjunct to the approval of that purchase, various financial statements as to the source of financing, the amounts of capitalization, methods of operation, anticipated incomes, interest and depreciation were submitted and considered by the governmental bodies designated in both the Public Health Law and the Official Rules and Regulations of the Department of Health. One of the purposes for such consideration was to obtain information upon which the

Commissioner could make a determination as to the advisability of approving the rates to be charged by the facility. That information should have included the sufficiency of the Medicaid reimbursement so as to assure the financial integrity of the venture.

Public Health Law, §2807, subd. 3, states:

> "Prior to the approval of such rates, the commissioner shall determine and certify to the superintendent of insurance and the state director of the budget that the proposed rate schedules for payments for hospital and health-related service, including home health service, *are reasonably related to the costs of efficient production of such service.* In making such certification the commissioner shall take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the hospital or agency is located; the rate of increase or decrease of the economy in the area in which the hospital or agency is located, costs of hospitals or agencies of comparable size, and the need for incentives to improve services and institute economies. The commissioner shall also take into consideration the economies and improvements in service to be anticipated from the operation of joint central service or use of facilities or services which may serve as alternatives or substitutes for the whole or any part of in-hospital service, including but not limited to * * * nursing home, ambulatory or home care services." (Emphasis supplied.)

In addition to the foregoing, Public Health Law, §2803, sets

forth the powers and duties of the commissioner and the Public Health Council. Among the powers and duties is the inquiry into the adequacy of financial resources and sources of future revenues (see subd. 1). Subd. 2 of this statute calls for establishment and effectuation of a uniform statewide system of reports and auditing, establishment by the department of schedules of rates, payments, reimbursements, grants and other charges as provided in Public Health Law, §2807. These mandatory statutory provisions take precedence over the rules and regulations of the Department of Health which are in conflict therewith.

In the instant matter of Commissioner of the Department of Health by William F. McCann, Assistant Commissioner, Division of Health Economics, by letter dated June 2, 1972, stated that they had reviewed the sale of the nursing home (petitioner) and revised the reimbursement rate. In that letter he states "the rate was revised March 1, 1972 effective *July 1, 1971*" and this he could not do. (Emphasis supplied.) Apparently a formula for rate determination has been utilized by the Commissioner different from that contemplated by petitioner and from the one in effect at the time of the instant purchase. As a result petitioner claims they were denied reimbursement for their actual property costs in the sum of $117,375 per annum.* It is further claimed that the Commissioner Utilized Sect. 86.32 of the Official Rules and Regulations to their detriment in this regard.

Section 86.32, sought to be declared void herein, is not void in the Court's opinion. Nor has it been shown to be in violation of the statutory requirements set forth in Public Health Law, §2807(3). The fact that the regulation states that "the basis for

* Petitioner noted in the Appellate Courts that its claim had been overstated and that the sum should be $115,100.

depreciation, allowable interest, and, if a proprietary facility, a return on owner's equity *to a new owner* in the sale of a facility *will be reasonable value* determined in a manner prescribed by the State Commissioner of Health" does not in and of itself present any conflict with Public Health Law, §2807(3). (Emphasis supplied.) The reasonable value noted in the regulation would of necessity include the items designated and made obligatory in the statute cited. Whether or not the Commissioner will consider these items is not before the Court at this time. Hypothetical adjudications are not made when there is no justiciable controversy before the court and when the presence of such a controversy depends on the happening of an event in the future (*Park Avenue Clinical Hospital v. Kramer*, 26 A D 2d 613, aff'd 19 N Y 2d 958) In any event Sect. 86.32 is inapplicable to petitioner in that its effective date is August 17, 1971, approximately a month and a half after petitioner actually purchased the facility with complete approval. Since the sale had already been consummated prior to the enactment of the regulation, it is inapplicable to petitioner. While the Commissioner's determination will be supported if it has a reasonable basis and is neither arbitrary nor capricious, the standard to be applied must be announced in advance (*Matter of Sigety v. Ingraham*, 29 N Y 2d 110).

Petitioner is entitled to the same computation method for rate establishment in existence on June 28, 1971, which was the date of purchase.

Accordingly, this matter is referred back to the Commissioner of the Department of Health for establishment of the proper rate in accordance with this opinion.

Settle judgment on notice.

APPENDIX II

RELEVANT CONSTITUTIONAL, STATUTORY, AND REGULATORY PROVISIONS

Constitution of United States

AMENDMENT XIV.

§1. Citizenship rights not to be abridged by States

Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

42 United States Code

§1396a. State plans for medical assistance

(a) Contents. A State plan for medical assistance must —

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

• • •

(5) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan

shall be made by the State or local agency administering the State plan approved under title I or XVI [42 USCS §§301-304, 306, 1381-1383c of this title] (insofar as it relates to the aged);

• • •

(8) Provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

• • •

(13) provide —

(E) effecive July 1, 1976, for payment of the skilled nursing faciiity and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by

• • •

(30) provides such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4) [42 USCS §1396b(i)(4)]) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care; • • •

§1396c. Operation of State plans

If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title [42 USCS §§1396-1396d, 1396f-1396i], finds —

(1) that the plan has been so changed that it no longer complies with the provisions of section 1902 [42 USCS §1396a]; or

(2) that in the administration of the plan there is a failure to comply substantialiy with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

New York State Constitution

Art. 4, §8. [Departmental rules and regulations; filing; publication]

No rule or regulation made by any state department, board, bureau, officer, authority or commission, except such as relates to the organization or internal management of a state department, board, bureau, authority or commission shall be effective until it is filed in the office of the department of state. The legislature shall provide for the speedy publication of such rules and regulations, by appropriate laws.

Social Services Law

§363-a. Federal aid; state plan

1. The department shall submit a plan for medical assistance, as required by title XIX of the federal social security act, to the federal department of health, education and welfare for approval pursuant to the provisions of such law and shall act as the single state agency to supervise the administration of the plan in this state. The department shall act for the state in any negotiations relative to the submission and approval of such plan and it may make such arrangements, not inconsistent with law, as may be required by or pursuant to federal law to obtain and retain such approval and to secure for the state the benefits of the provisions of such law.

§364-a. Cooperation of state departments

2. Notwithstanding any inconsistent provision of this title, not later than October thirty-first, nineteen hundred sixty-six the department shall enter into a cooperative agreement with the department of health which shall (i) provide for the department of health, on and after such date, to administer and supervise the medical care and health services provided pursuant to this title, and (ii) authorize the department of health to perform such administration and supervision either directly or by contract with county health districts, part-county health districts or city health departments or boards of health in cities with populations exceeding fifty thousand as the department of health may from time to time determine. On and after the effective date of such agreement all of the functions provided for in this title for the administration and supervision of medical care and services provided hereunder shall be performed by the department of health to the extent permitted by applicable federal law and to the extent federal reimbursement for such care and service is not impaired.

Public Health Law

§12. Violations of health laws or regulations; penalties and injunctions

1. Any person who violates, disobeys or disregards any term or provision of this chapter or of any lawful notice, order or regulation pursuant thereto for which a civil penalty is not otherwise expressly prescribed by law, shall be liable to the people of the state for a civil penalty of not to exceed one thousand dollars for every such violation.

§12-b. Wilful violation of health laws

2. A person who wilfully violates any provision of this chapter, or any regulation lawfully made or established by any public officer or board under authority of this chapter, the punishment for violating which is not otherwise prescribed by this chapter or any other law, is punishable by imprisonment not exceeding one year, or by a fine not exceeding two thousand dollars or by both.

§206. Commissioner; general powers and duties

* * *

4. The commissioner may:

* * *

(c) assess any penalty prescribed for a violation of or a failure to comply with any term or provision of this chapter or of any lawful notice, order or regulation pursuant thereto, not exceeding one thousand dollars for every such violation or

failure, which penalty may be assessed after a hearing or an opportunity to be heard.

§220. Public health council; appointment of members

There shall continue to be in the department a public health council to consist of the commissioner and fourteen members to be appointed by the governor with the advice and consent of the senate.

§2801. Definitions

The following words or phrases, as used in this article, shall have the following meanings, unless the context otherwise requires:

1. "Hospital" means a facility or institution engaged principally in providing services by or under the supervision of a physician or, in the case of a dental clinic or dental dispensary, of a dentist, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition including, but not limited to, a general hospital, public health center, diagnostic center, treatment center, dental clinic, dental dispensary, rehabilitation center other than a facility used solely for vocational rehabilitation, nursing home, tuberculosis hospital, chronic disease hospital, maternity hospital, lying-in-asylum, out-patient department, dispensary and a laboratory or central service facility serving one or more such institutions, but the term hospital shall not include an institution, sanitarium or other facility engaged principally in providing services for the prevention, diagnosis or treatment of mental disability and which is subject to the powers of visitation, examination, inspection and investigation of the department of mental hygiene except for those distinct parts of such a facility which provide hospital service.

2. "Nursing home" means a facility providing therein nursing care to sick, invalid, infirm, disabled or convalescent persons in addition to lodging and board or health-related service, or any combination of the foregoing, and in addition thereto, providing nursing care and health-related service, or either of them, to persons who are not occupants of the facility.

3. (a) "Hospital service" means the preadmission, out-patient, in-patient and post discharge care provided in or by a hospital, and such other items or services as are necessary for such care, which are provided by or under the supervision of a physician for the purpose of prevention, diagnosis or treatment of human disease, pain, injury, disability, deformity or physical condition, including, but not limited to, nursing service, home-care nursing and other paramedical service, ambulance service, service provided by an intern or resident in training, laboratory service, medical social service, drugs, biologicals, supplies, appliances, equipment, bed and board.

(b) "Health-related service" means service in a facility or facilities which provide or offer lodging, board and physical care including, but not limited to, the recording of health information, dietary supervision and supervised hygienic services incident to such service.

(c) Repealed.

4. "Construction" means the erection, building, or substantial acquisition, alteration, reconstruction, improvement, extension or modification of a hospital, including its equipment; the inspection and supervision thereof; and the studies, surveys, designs, plans, working drawings, specifications, procedures and other actions necessary thereto.

5. "Council" means the state hospital review and planning council.

6. "Government agency" means a department, board, bureau, division, office, agency, public benefit or other corporation, or any other unit, however described, of the state or a political subdivision thereof.

§2801-a. Establishment or incorporation of hospitals

1. No hospital, as defined in this article, shall be established except with the written approval of the public health council. No certificate of incorporation of a business, membership or not-for-profit corporation shall hereafter be filed which includes among its corporate purposes or powers the establishment or operation of any hospital, as defined in this article, or the solicitation of contributions for any such purpose, or two or more of such purposes, except with the written approval of the public health council, and when otherwise required by law of a justice of the supreme court, endorsed on or annexed to the certificate of incorporation.

2. With respect to the incorporation or establishment of any hospital, as defined in this article, the public health council shall give written approval after all of the following requirements have been met. An application for approval of the proposed certificate of incorporation or establishment shall be filed with the public health council together with such other forms and information as shall be prescribed by, or acceptable to, the public health council. Thereafter, the public health council shall forward a copy of the proposed certificate or application for establishment and accompanying documents, to the state hospital review and planning council and the regional hospital review and planning council having

geographical jurisdiction of the area where the proposed institution is to be located. The public health council shall act upon such application after the state and regional councils have had a reasonable time to submit their recommendations. The public health council shall not take any action contrary to the advice of either until it affords to either an opportunity to request a public hearing and, if so requested, a public hearing shall be held. If the public health council proposes to disapprove the application it shall afford the applicant an opportunity to request a public hearing. The public health council may hold a public hearing on the application on its own motion. Any public hearing held pursuant to this subdivision may be conducted by the public health council, or by any individual designated by the public health council.

3. The public health council shall not approve a certificate of incorporation or application for establishment unless it is satisfied, insofar as applicable, as to (a) the public need for the existence of the institution at the time and place and under the circumstances proposed, provided however, that in the case of an institution proposed to be established or operated by an organization defined in subdivision one of section four hundred eighty-two-a of the social services law, the needs of the members of the religious denomination concerned, for care or treatment in accordance with their religious or ethical convictions, shall be deemed to be public need; (b) the character, competence, and standing in the community, of the proposed incorporators, directors, sponsors or stockholders; (c) the financial resources of the proposed institution and its sources of future revenues; and (d) such other matters as it shall deem pertinent.

§2802. Approval of construction

The construction of a hospital, whether public or private, incorporated or not incorporated, shall require the prior approval of the commissioner.

1. An application for such construction shall be filed with the department, together with such other forms and information as shall be prescribed by, or acceptable to, the department. Thereafter the department shall forward a copy of the application and accompanying documents to the state hospital review and planning council and the regional hospital planning council having geographical jurisdiction of the area where the hospital is located.

2. The commissioner shall not act upon an application for construction of a hospital unless (a) the applicant has obtained all approvals and consents required by law for its incorporation or establishment (including the approval of the public health council pursuant to the provisions of this article) and until the state hospital review and planning council and the regional hospital planning councils concerned have had a reasonable time to submit their recommendations; and (b) the commissioner is satisfied as to the public need for the construction, at the time and place and under the circumstances proposed, provided however that, in the case of an application by a hospital established or operated by an organization defined in subdivision one of section four hundred eight-two-a of the social services law, the needs of the members of the religious denomination concerned, for care or treatment in accordance with their religious or ethical convictions, shall be deemed to be public need.

§2803. Commissioner and council; powers and duties

1. The commissioner shall have the power to inquire into the operation of hospitals and to conduct periodic inspections of facilities with respect to the fitness and adequacy of the premises, equipment, personnel, rules and by-laws, standards of medical care, hospital service, including health-related service,

system of accounts, records, and the adequacy of financial resources and sources of future revenues.

2. The council, by a majority vote of its members, shall adopt and amend rules and regulations, subject to the approval of the commissioner, to effectuate the provisions and purposes of this article, including, but not limited to (a) the establishment of requirements for a uniform statewide system of reports and audits relating to the quality of medical and physical care provided, hospital utilization and costs, (b) establishment by the department of schedules of rates, payments, reimbursements, grants and other charges for hospital and health-related services as provided in section two thousand eight hundred and seven, (c) standards and procedures relating to hospital operating certificates, and (d) the establishment of a system of accounts and cost finding to be used by hospitals, including a classification of such hospitals and the prescription of a system of accounts and cost finding for each class. The commissioner may propose rules and regulations and amendments thereto for consideration by the council.

3. The commissioner may enter into contracts with any political subdivision, voluntary non-profit agency or regional hospital council and such entities are authorized to enter into contracts with the commissioner to effectuate the purposes of this article.

4. At the request of the commissioner, hospitals shall furnish to the department such reports and information as it may require to effectuate the provisions of this article.

5. The commissioner may institute or cause to be instituted in a court of competent jurisdiction proceedings to compel compliance with the provisions of this article or the determinations, rules, regulations and orders of the commissioner or the council.

§2807. Payments for hospital and health-related service

1. No government agency and no corporation organized and operating in accordance with article nine-c of the insurance law shall purchase, pay for or make reimbursement or grants-in-aid for any hospital or health-related service unless, at the time the service was provided, the hospital possessed a valid operating certificate authorizing such service.

2. Payments for hospital service and health-related service made by government agencies or corporations organized and operating in accordance with article nine-c of the insurance law shall be at rates approved by the state director of the budget in the case of government agencies and approved by the superintendent of insurance in the case of corporations organized and operating under article nine-c of the insurance law. Notwithstanding the foregoing, rates of payment for hospital and health-related service made by government agencies, approved by the state director of the budget and in effect March thirty-first, nineteen hundred sixty-nine shall continue in effect for the period ending December thirty-first, nineteen hundred sixty-nine. Rates approved by the state director of the budget for the first time after March thirty-first, nineteen hundred sixty-nine shall continue in effect for the period ending December thirty-first, nineteen hundred sixty-nine.

3. Prior to the approval of such rates, the commissioner shall determine and certify to the superintendent of insurance and the state director of the budget that the proposed rate schedules for payments for hospital and health-related service are reasonably related to the costs of efficient production of such service. In making such certification, the commissioner shall take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors

in the area in which the hospital is located, the rate of increase or decrease of the economy in the area in which the hospital is located, costs of hospitals of comparable size, and the need for incentives to improve services and institute economies. The commissioner shall also take into consideration the economies and improvements in service to be anticipated from the operation of joint central service or use of facilities or services which may serve as alternatives or substitutes for the whole or any part of in-hospital service, including, but not limited to, obstetrical, pediatric, laboratory, training, radiology, pharmacy, laundry, purchasing, preadmission, nursing home, ambulatory or home care services. The commissioner shall exclude costs for research, those parts of the costs for educational salaries which the commissioner shall determine to be not directly related to hospital service, and allowances for costs which are not specifically identified.

§2904. State hospital review and planning council

(a) There is hereby created within the state department of health a state hospital review and planning council comprised of thirty-one persons appointed by the governor by and with the advice and consent of the senate. In making such appointments the governor shall consider recommendations from agencies and organizations primarily concerned with hospital, nursing home and medical affairs. The council shall be representative of the public including persons having capacities identified with consumers of hospital and nursing home services. The council shall include at least one member nominated initially by each of the regional hospital planning councils named in paragraph (d) of this section and thereafter by each regional council recognized by the state council as hereinafter provided. At least six members shall be persons engaged in hospital or nursing home work at the policy-making or administrative level. At least six members shall be duly licensed physicians. No more than fifteen

members of the council shall be physicians, or persons engaged in full-time paid employment connected with hospitals or nursing homes. However, a change in the status or employment of a member of the council shall not require his resignation or a change in the composition of the council until further appointments are made. The members of the council shall have fixed terms of three years except that ten of the initial appointments shall be for one year and ten shall be for two years. No person shall be a member of the council for more than six years in any period of twelve consecutive years. The council shall meet at least four times in each full calendar year.

(b) The council shall consult with the department of health in carrying out state plans submitted pursuant to the requirements of this article and the federal laws relating thereto.

State Regulations

10 N.Y.C.R.R. 86.24 (Prior to July 1, 1971)

Interest.

(a) Necessary interest on both current and capital indebtedness is an allowable cost for all medical facilities.

(b) To be considered as an allowable cost, interest must be incurred to satisfy a financial need, and at a rate not in excess of what a prudent borrower would have had to pay in the money market at the time the loan was made. Also, the interest must be paid to a lender not related through control, ownership, affiliation or personal relationship to the borrower, except in instances where the prior approval of the Commissioner of Health has been obtained.

(c) Interest expense must be reduced by investment income with the exception of income from funded depreciation,

qualified pension funds, or in instances where income from gifts or grants is restricted by donors. Interest on funds borrowed from a donor restricted fund or funded depreciation is an allowable expense.

10 N.Y.C.R.R. 86.24 (Amendment added subsequent to sale)

* * *

(d) Interest on capital debt in excess of 50% of the net depreciated value of buildings and fixed equipment for voluntary facilities will not be considered an allowable cost unless the Commissioner of Health, as of July 1, 1971, has already finally approved the fiscal feasibility of a project, or thereafter shall have determined, after inviting written comments from interested parties, that capital debt in excess of such amount is a matter of public interest and does not threaten the continued existence of the institution.

(e) Interest on capital debt incurred in part or in whole after July 1, 1971 that is in excess of 75% of the net depreciated value of buildings and fixed equipment for proprietary facilities will not be considered an allowable cost. In instances where capital debt exceeds 75% of such value and the amount of interest considered as an allowable cost is limited, the computation of the reimbursement rate will include either an amount equal to the amount which would have been included under section 86.29 of this Part had the operators invested additional capital equal to the amount on which interest is not considered an allowable cost or the interest paid, whichever is lower. In no event shall the total amount on which either interest or return on equity is computed exceed such net depreciated value. In these cases, return on equity will be computed on the basis of the percent return in effect as of the date on which the debt was incurred.

10 N.Y.C.R.R. 86.29 (Prior to July 1, 1971)

Return on investment.

(a) In computing the allowable costs of a proprietary medical facility, there will be included an amount equal to 10 percent of the net equity capital of the institution.

(b) Equity capital is the net worth of the provider adjusted for those assets and liabilities which are not related to the provisions of patient care. Equity capital consists of the provider's investment in plant, property and equipment, net of depreciation, and working capital for necessary and proper operation of patient care activities.

10 N.Y.C.R.R. 86.29 (Amended subsequent to sale)

(a) In computing the allowable costs of a proprietary medical facility, there will be included an allowance of a reasonable return on the net equity capital representing the investment by an owner used for the provision of patient care. The percentage to be used in computing the allowance will be a rate determined annually by the Commissioner as reasonably related to the then current money market.

10 N.Y.C.R.R. 86.32 (Effective subsequent to sale)

Sale of new facilities. The basis for depreciation, allowable interest, and if a proprietary facility, a return on owner's equity to a new owner in the sale of a facility, will be reasonable value determined in a manner prescribed by the State Commissioner of Health.

10 N.Y.C.R.R. 620.2

Transfers of interest by sole proprietors or partnerships. An individual or partnership seeking Public Health Council approval of transfer of all or part of the ownership of

the business shall file information, documents and data as follows:

(a) A certified copy of the applicant's certificate of doing business.

(b) Where the applicant is a partnership, full and true copies of all partnership agreements.

(c) A declaration of the percentage of the business to be transferred.

(d) A financial statement setting forth the purchase price of the interest in the business being sold and the financial resources available to make such purchase, or the basis on which such transfer is to be financed.

(e) Where any transfer is to be by gift, a statement of the relationship between the donor and donee.

(f) Information as to the character, experience, competence and standing in their community of the proposed proprietor or partners.

(g) Such additional pertinent information or documents necessary for the council's consideration, as requested.

10 N.Y.C.R.R. 730.2

Admissions. The operator shall:

* * *

(g) assess no additional charges, expenses or other financial liabilities in excess of the daily, weekly or monthly basic rate included in the admission agreement except:

(1) upon express written approval and authority of the patient, next of kin or sponsor;

(2) upon express written orders of the patient's personal, alternate or staff physician stipulating specific services and supplies not included in the admission agreement;

(3) upon 10 days' prior written notice to the patient, his next of kin or sponsor, of additional charges, expenses or other financial liabilities due to the increased cost of maintenance and/or operation of the nursing home; and upon request of the patient, his next of kin or sponsor, or of the department, financial and statistical supportive evidence sufficient to reflect such change in economic status shall be provided; or

* * *

(l) not discriminate because of race, color, blindness or sponsorship in admission, retention and care of patients.

APPENDIX III

FEDERAL ISSUES RAISED IN STATE COURT

Equal Protection Under the Fourteenth Amendment, United States Constitution:

The petition in the Supreme Court alleged in Paragraph 34 thereof, *inter alia*, "That the actions of the Commissioner were . . . . unconstitutional". In an affidavit of Stanley H. Lowell, in support of the petition, sworn to June 8, 1973, counsel referred the Supreme Court to an accompanying memorandum of law as to the basis for the claim of unconstitutional action. Point II of petitioner's brief consisted of eight pages (with federal authority cited) devoted to the subject of the headnote entitled:

"RESPONDENTS' ACTIONS VIOLATE THE EQUAL PROTECTION GUARANTEE OF THE FOURTEENTH AMENDMENT". The thrust of petitioner's argument appeared at page 37 of its Supreme Court brief when petitioner stated:

> "In affect, Petitioner was singled out for special treatment by being denied actual property costs as required by Sections 86.24 and 86.29, while homes that had been transferred previously received their full costs."

This equal protection argument under the Fourteenth Amendment was repeated with the same headnote offering federal authorities and containing the basic arguments at pages 30 through 33 of the printed brief to the Appellate Division and was reasserted at several places in the brief in the Court of Appeals. At page 23 of its brief in the Court of Appeals petitioner stated:

> ". . . In no other case have respondents acted in similar fashion. Appellant submits that such special treatment offends the Fourteenth Amendment of the United States Constitution. . . as a. . . taking of property without due process and a denial of the equal protection of the laws."

Due Process Under the Fourteenth Amendment, United States Constitution:

The Appellate Division having reversed the Supreme Court, petitioner raised the issue of a denial of due process in its brief to the Court of Appeals. At page 5 of its brief petitioner noted:

> "Appellant's economic viability is dependant on the Medicaid rate, and appellant by law may not discriminate in the admission, retention and treatment of Medicaid covered patients [10 N.Y.C.R.R. 730.2(1)]"

At page 16 of its brief petitioner noted that *ex post facto* application of regulations is permissible only where vested property rights are not impaired citing this Court's decision in *Lynch v. United States*, 292 U.S. 571, 78 L. Ed. 1434, 54 S. Ct. 641 and *Etor v. City of Tacoma*, 228 U.S. 148, 156, 57 L. Ed. 773, 33 S. Ct. 428.

At page 23, appellant summarized its due process argument under the Fourteenth Amendment when it stated:

> ". . . appellant. . . is being compelled to render mandated services at less than its approved real property costs. . . .In no other case have respondents acted in a similar fashion. Appellant submits that such special treatment offends the Fourteenth Amendment of the United States Constitution. . . , as a taking of property without due process and a denial of the equal protection of the laws."

At pages 23-24 petitioner concluded:

> "While respondent's goal of Medicaid cost control is not at issue as a broad principle, a simple refusal to approve the proposed sale and transfer would have achieved such statutory goal without action which resulted in wholesale violations of constitutional protections, as well as the rules of law. (cases cited) The protection of

appellant's rights in this regard is essential, for what is truly involved is a personal right to enjoy property and to be governed by law, and these rights are as basic as any others constitutionally protected.

If this Court's admonition in *Sigety*, that reimbursement is to be governed by regulations prospectively announced, is to have meaning, such regulation must be binding not only on the regulated but also on the regulator in identical fashion. There is no place in our democratic society for an intermittent and arbitrary administration of the laws."

IN THE

Supreme Court of the United States

OCTOBER TERM, 1976

76-1580

In the Matter of the Application of
SANDS POINT NURSING HOME,
Petitioner,

against

HOLLIS S. INGRAHAM, as Commissioner of Health of the State of New York and RICHARD L. DUNHAM, as Budget Director of the State of New York,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE COURT OF APPEALS OF THE STATE OF NEW YORK

RESPONDENTS' BRIEF IN OPPOSITION

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On Petition for a Writ of Certiorari to the Court of Appeals of the State of New York

RESPONDENTS' BRIEF IN OPPOSITION

Opinions Below

The February 10, 1977, decision of the New York Court of Appeals which this Petition seeks to review is reported at 41 N Y 2d 837 (1977). It affirmed the decision of the Appellate Division, Second Department, which is reported at 48 A D 2d 897 (1975). The Appellate Division had dismissed petitioner's Article 78 petition on the merits and confirmed the determination of respondent the Com-

missioner of Health of the State of New York. In so doing it unanimously reversed the decision of the Supreme Court, Nassau County (MEADE, J.), entered on December 4, 1973, granting the petition in part. That decision is not reported, but is reproduced at pp. 10a, *et seq.* of the Petition.

Jurisdiction

The jurisdictional facts are set forth in the Petition.

Question Presented

Whether in setting the Medicaid reimbursement rate for the Sands Point Nursing Home, the Commissioner of Health was required to use the purchase price as the value of the property, even though he had determined that that was an unreasonably high value when no statute or regulation required that method?

The Appellate Courts below answered "No" as the respondents had contended and reversed the decision of Special Term which had held that the Commissioner was required to use the purchase price as the basis for the reimbursement rate.

Statute Involved

New York Public Health Law § 2807(3) as it existed at all times relevant to these proceedings provided in pertinent part:

> "Prior to the approval of such rates, the commissioner shall determine and certify to the superintendent of insurance and the state director of the budget that the proposed rate schedules for payments for hospital and health-related service are reasonably related to the costs of efficient production of such service."

In 1972 (L. 1972 c. 918 § 8, eff. April 1, 1973) and in 1976 (L. 1976 c. 938 § 6, eff. July 27, 1976) the language was changed but not to affect the standards quoted above.

Statement

This petition involves a determination of the property component of the Medicaid reimbursement rate for one nursing home. The rate was found to be "reasonably related to the costs of efficient production" (Pub. Health L. § 2807[3]) of nursing home services by two appellate courts of the State of New York based on the particular facts of the case.

This standard is fair and in conformity with the Constitution of the United States.

The question enumerated as "3" in the petition (Pet'n., p. 3) whether the determination of property costs by using appreciated value of property depreciated over its life violated the federal Social Security Act was not raised in the petition filed under Article 78, New York Civil Practice Law and Rules, in its brief in the courts below or ruled on by those courts. Quite the contrary, it was respondents who consistently have relied on Federal regulations to support the reasonableness of the rate setting in this case (see p. 7, *infra*).

The Sands Point Nursing Home was built in 1965 and in 1970, subject to straight line depreciation of 2½% a year, was valued at $508,943.00 (92 [p. 9*]). In that year the property costs were determined to be $117,714 or roughly $900 per bed per year (92 [p. 17]). Almost 50% of the net revenue from services to patients in the 6-month period ending June 30, 1970 was from private patients (92 [p. 16]).

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* Unless otherwise designated numbers in parentheses refer to pages of the Record on Appeal submitted in the courts below.

Effective June 30, 1971, the facility was sold to the partners who presently own it for $2,145,000 (94 [p. 4]). The establishment of the Nursing Home by the new owners was approved by the Public Health Council (94).

On August 20, 1971, petitioner sought a revision in the property cost component of the Medicaid reimbursement rate on the basis of the purchase price of the facility at a rate of $260,375 per year or an average annual rate per bed of $2,000 (29-30). Because this was such an enormous increase of costs over the previous year and because the Commissioner determined that the purchase price reflected value other than the tangible assets, he made an independent evaluation of the property costs, using the recognized method of determining the value of the building by taking the reproduction cost less accumulated depreciation. See CCH Medicaid and Medicare Guide ¶ 4681, pp. 1641-3. The fair return on that property was found to be $143,000 a year or about $1,100 per bed (32-4). While lower than the $2,000 per bed rate sought by petitioner, this cost represented an increase of 22% over the property costs of the previous year (92 [p. 16]). The new rate was made retroactive to July 1, 1971 when the new property costs accrued.

Petitioner's objections were rejected by the Commissioner on August 28, 1972 (32-6, 37-8, 40).

Petitioner sought review of the Commissioner's decision by way of an Article 78 proceeding brought in the Nassau County Supreme Court. On October 5, 1973, Justice Meade issued his opinion which found that petitioner had contemplated that he would be reimbursed for the "actual property costs," i.e., the purchase price and that the Commissioner used a different rate. The Court rejected the rates established and required the Commissioner to establish a "proper rate" (13). The Court also stated that the Commissioner of Health revised the reimbursement rate on March 1, 1972, effective July 1, 1971* "and this he couldn't do" (12). The court did not declare 10 N.Y.C.R.R. § 86.32 to be void as petitioner had claimed, because its effective date was a month after the purchase of the facilities and was therefore inapplicable to the rate at issue (12-13).

The Appellate Division, Second Department reversed the judgment (150) on June 23, 1975, in a unanimous decision which held (154):

> ". . . the Medicaid reimbursement rate . . . fixed by the appellant State Commissioner of Health for the new owner's property cost factor was authorized and consistent with the mandate of subdivision 3 of section 2807 of the Public Health Law, which provides that rates be 'reasonably related to the costs of efficient production of such service.' That determination was reasonable, was authorized by statute, and should not be disturbed (*Matter of Sigety* v. *Ingraham*, 29 N Y 2d 110, 324 N.Y.S. 2d 10, 272 N.E. 2d 524)."

On February 10, 1977 the Court of Appeals affirmed the decision (FUCHSBERG, J., dissenting) 41 N Y 2d 837 (1977).

Early in 1975 Robert P. Whalen became Commissioner of Health and Peter Goldmark, Budget Director. Pursuant to CPLR §§ 1019, 1023, 5511 they were automatically substituted as respondents in the Court of Appeals.

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* The rate had been at $900 per bed under the prior owners. The revision was sought by petitioner on August 20, 1971 (29-30). Had the rate not been revised retroactively petitioner would have received a $900-per-bed reimbursement for property costs for the period between July 1, 1971 and March 21, 1972 rather than $1100 a bed.

Reasons for Denying Certiorari

I.

The decisions of the Court of Appeals and Appellate Division are clearly correct.

In exercising his authority under Public Health Law § 2807(3) the Commissioner determined that the property cost reimbursement sought by petitioner was not "reasonably related to the costs of producing [nursing home] service" (Public Health Law § 2807[3]). By any measure, the Commissioner's determination was itself reasonable and should not be disturbed.

The cost increase sought by petitioner for the same service was 122% or from $900 per bed per year to $2,000 per bed per year. This increase is unreasonable on its face. There were no improvements to property to warrant such an increase in costs.

The rate of property cost reimbursement sought by petitioner was based on the total purchase price for the facility when that price obviously paid for more than the tangible assets represented in the property cost—good will and anticipated increased revenue from both private and Medicaid patients. It would be unreasonable for the Commissioner to have allowed the price for intangible profit producing assets to be included in property costs. Those relating to private patient revenue are irrelevant and those relating to Medicaid patients would become self-fulfilling prophecies of ever higher Medicaid costs (86-7).

No statute or regulation required the Commissioner to use the purchase price as the value of the property. Petitioner's request for a rate revision was not related to increased "costs of efficient production of such service," the statutory standard (Public Health Law § 2807[3]). Since those services had been produced for less than half the cost

the year before, petitioner cannot claim to be efficiently producing the services. The regulation in effect at the time (former 10 N.Y.C.R.R. § 86.24) provided:

> "Necessary interest on both current and capital indebtedness is an allowable cost for all medical facilities."

The use of the word "allowable" belies any reasonable reliance on an anticipated rate based on actual purchase price. There is no requirement that it must be allowed.

The cost basis employed by the Commissioner was one recognized by the regulations of the United States Department of Health, Education and Welfare (HEW). HEW set property costs as the lowest of three values: the purchase price, fair market value or the current reproduction cost depreciated over its life. Medicaid and Medicare Provider Reimbursement Manual, § 104.14; CCH Medicaid and Medicare Guide ¶ 4681, p. 1641-3:

> "The cost basis of a facility acquired as an on-going operation in a bona fide sale on or after August 1, 1970 is limited to the lowest of the following: (a) fair market value of the tangible assets purchased, (b) price paid by the purchaser (i.e., actual cost) or (c) current reproduction cost depreciated on a straight-line basis over the useful life of the assets to the time of sale."

Here, the Department used the third method, the reproduction cost. This also disposes of petitioner's belated assertion that the methodology employed by the Commissioner violated the Social Security Act.

Since HEW reimburses the State for a least 50% of the costs of Medicaid (42 U.S.C. § 1396b, 1396d), it is to be expected that their guidelines will be referred to by the Commissioner in determining Medicaid reimbursement rates.

On August 8, 1971 the Commissioner formalized his reliance on HEW's regulations (10 N.Y.C.R.R. § 86.21):

> "Allowable costs. (a) Except as otherwise provided in these rules, allowable costs will be determined by the application of the principles of reimbursement developed for determining payments under the Title XVIII (Medicare) program."

Petitioner had no right to rely on the Commissioner's prior practice of using the purchase price as the property cost basis in arms length transactions, since he was not required to use that figure.

In upholding the Commissioner's actions, the courts below were following established precedent that the Commissioner was not bound by past practice, if he established rates according to the statutory standards of reasonableness, e.g. *Matter of Sigety* v. *Ingraham*, 29 N Y 2d 110, 342 N.Y.S. 2d 10 (1971).

Petitioner claims that new limits on property costs were being applied retroactively. However, the Commissioner always had the power to set property cost reimbursement rates based on the value of the tangible assets alone. The new regulations were not applied in this case (37-8, 90-1).

The approval of the establishment of the Nursing Home by the Public Health Council (94) does not constitute approval of the purchase price as the cost basis for Medicaid reimbursement. The plain answer to that assertion is that the Council approves the establishment pursuant to Public Health Law § 2801-a and 10 N.Y.C.R.R. § 600.1; but only the Commissioner may certify Medicaid reimbursement rates under Public Health Law § 2807(3).

The Council is concerned with the need for and the ultimate feasibility of the health facility and it is to this end that it looks at the financial situation of a health facility. Here with 5% of revenues reflected in the total property

costs, disagreement about this one aspect of the rate would not bar its establishment. In approving this establishment of petitioner, the Council specifically referred to the solvency of the proposed owners not the profitability of their investment (94, p. 5):

> "It appears the applicants have the financial capability to consummate the acquisition and operate Sands Point Nursing Home."

Both state and federal courts have held that in dealing with an agent of the government, one is on notice of the limitation of his authority. In *United States* v. *R.C.A.*, 358 U.S. 334, 79 S. Ct. 457, 3 L.Ed. 2d 354 (1950), this Court held that an approval by the Federal Communications Commission of an exchange of stations did not bar an action by the Federal Government under the anti-trust laws. Although the FCC could take anti-trust considerations into account in approving licenses, it was not given the power to finally determine those issues. Thus its action could not prevent the enforcement of those laws by the Justice Department. *Id.* at 346, 351.

In *Matter of 225 E. 70th St. Corp.* v. *Weaver*, 6 N Y 2d 197, 189 N.Y.S. 2d 153 (1959), the New York Court of Appeals held that the State Rent Administrator had a right to revise rent increases previously granted for capital expenditures if the landlord had since obtained an abatement of taxes because of the same improvements. Judge Fuld stated that there was no representation, express or implied, that the rents could not be reduced and the statute warned of the scope of the Administrator's power. Here, too, no representations were made as to the effect of the Council's approval and the statute warned that Medicaid reimbursement rates were set by the Commissioner, only. The Commissioner's actions were triply reasonable (1) the rate sought by petitioner was on its face unreasonable; (2) the method of rate fixing used by the Commissioner was reasonable; and (3) no other rate or method of rate fixing was mandated by law.

II.

No important constitutional issues are presented in this petition.

As the discussion in Point I, indicates, the decisions of the courts below were supported by ample precedent and well within the requirements of the federal law. No new troublesome issue is presented in this petition. The assertion that "... this Court has not previously addressed itself to the broad and vital question of Medicaid reimbursement to skilled nursing facilities ..." (Pet'n, p. 13), does not present a reason for granting review by this Court. Petitioner fails to present an appropriate question. This Court does not sit to discuss "the availability of care to the categorically and medically needy" in the absence of a federal legal question of importance. The thrust of the petition is to seek review of State administrative procedures, but petitioner has had full opportunity to be heard in the appropriate forums—the State administrative and judicial tribunals.

Petitioner fails to demonstrate any denial of rights protected by the federal Constitution. The property component of its medicaid rate was reasonable and reasonably arrived at; which is to say that petitioner was accorded due process of law, contrary to its conclusory assertion. The only authority cited by petitioner, a 1932 Opinion of Mr. Justice Roberts from which Justices Holmes and Brandeis dissented, *Arizona Grocery Co.* v. *Atchison, Topeka & Santa Fe Ry. Co.*, 284 U.S. 370 (1932), was not based on a constitutional determination, but on an interpretation of the Interstate Commerce Act. This was specifically held by Mr. Justice Cardozo for a unanimous Court in *Great Northern Ry. Co.* v. *Sunburst Oil & Refining Co.*, 287 U.S. 358, 362-3 (1932):

> "*Arizona Grocery Co.* v. *Atchison, T. & S. F. Ry. Co.*, 284 U.S. 370, holds nothing to the contrary. This court in disposing of that case was not dealing with any question of constitutional law. It was construing a federal statute . . . The opinion of the court does not speak of the constitution, but plants itself upon the statute, and from that source and no other derives its energy."

In *Great Northern* this Court upheld as constitutional an interpretation of a State (Montana) statute which fixed railroad rates, but permitted them to be set aside by the State Board or a court if found to be unreasonable. Although that interpretation was rejected by the highest Court of Montana, it did not give retroactive effect to the decision, so that the retroactive rate adjustment in this case was held to be constitutional. This Court recognized the freedom of the States to experiment and change regulatory procedures (*Id.* at 363).

Great Northern, unlike *Arizona Grocery Co.*, is pertinent to this petition and disposes of it. Rate setting under the relatively new medicaid statute, in the 70's is like rate-setting for railroads was in the 20's and 30's—a developing field—where, experimentation and changes in federal and state policy based on experience, may be expected to occur.

III.

The decisions below were based on the particular facts of this rate fixing and are not likely to recur.

The decisions below were based on regulations which were changed a month after this facility was purchased by the present owners almost 6 years ago (10 N.Y.C.R.R. Part 86, for example §§ 86.21, 86.24, 86.29, 86.32). Petitioner alleges that it was "singled out" (Pet'n., p. 8) not to be reimbursed on the basis of purchase price. In defending his determination as being reasonable under the provisions of Public Health Law § 2807(3), Deputy Commissioner

McCann stated "This was the greatest increase in property costs from a sale of a nursing home I had seen" (86).

Since August, 1971, the methodology for determining the property cost component of nursing home rates in this situation has been set forth in detail in the regulations of the Department of Health since 1971 (10 N.Y.C.R.R. Part 86) so that petitioner's complaint has no importance for the future.

CONCLUSION

For these reasons, the petition for a writ of certiorari should in all respects be denied.

Dated: New York, New York, June 14, 1977

Respectfully submitted,

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Supreme Court, U. S.
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PETITIONERS' REPLY BRIEF

A. RESPONDENTS' POINT I IN SUPPORT OF DENYING CERTIORARI

Respondents argue that: (1) no statute or regulation required the Commissioner to use purchase price as the basis for determining property cost reimbursements (R.6);[1] (2) Petitioner had no right to rely upon past practices of the Commissioner in applying and interpreting the reimbursement regulations, but should have anticipated that respondents would have applied

1. References to the letter "R" followed by a number(s) refer to page(s) in respondents' brief.

Medicare principles of reimbursement (Title XVIII, Social Security Act, 42 U.S.C. §1395, *et seq.*) to Medicaid reimbursement (R.7, 8); (3) Public Health Council approval of the proposed sale did not restrict the Commissioner in his rate setting function (R.8, 9). Each contention is without merit.

1. The Regulations Controlled Petitioner's Reimbursement

The reimbursement regulations of the State were submitted to and incorporated verbatim into the State Plan approved by HEW for determining Medicaid reimbursement on a prospective basis. The decision of the Court of Appeals in *Sigety v. Ingraham* (P.3a-8a)[2] made clear that New York had devised a system of Medicaid reimbursement pursuant to which prospective rates would be calculated. The methodology was contained in promulgated regulations applicable to all. State statutes did not provide for or permit an individual determination of a rate. If the regulations so promulgated were reasonable, the result would not be disturbed even if hardship resulted to one facility, and another prospered under the methodology. However, as the decision made clear, it involved a period when Medicaid participation was *voluntary* for the facility. Subsequent to the rate year referred to in *Sigety*, and prior to the transaction which is the subject of this petition, the Health Department adopted 10 NYCRR §730.2(1) (P.31a) which made participation in the Medicaid program *mandatory*. This regulation coupled with the prohibition against supplementation of Medicaid reimbursement, 10 NYCRR §730.2(g) (P.30a), compelled petitioner, a private enterprise, to carry on a public purpose. Accordingly, as petitioner could refuse Medicaid patients only at the risk of civil and criminal sanctions (Public Health Law §§12, 12-b, 20-b [P.18a-19a]) it had a constitutionally protected and vested interest in receiving reimbursement in accordance with the regulations, and was entitled to protection against an arbitrary administrative act in

2. References to the letter "P" followed by a number(s) refer to the page(s) in the petition to this Court.

applying prospective regulations retroactively and selectively to petitioner only. By such action, without legislative authority, petitioner was placed in the position of rendering public services at substantially less than its contractually fixed costs. By reason of the foregoing petitioner's property was taken without due process of law. *Lynch v. United States*, 292 U.S. 571, 577, 579; *Etor v. City of Tacoma*, 228 U.S. 148; *Matter of Bayswater v. Karaghuezoff*, 37 N.Y.2d 408; *Larionoff v. United States*, 553 F.2d 1176 (1976 C.C.A., D.C.), *cert. granted*, 50 L. Ed. 2d 607, 97 S. Ct. 522.

Petitioner had no advance notice by reason of the Public Health Law §§2803, 2807 (P.23a-26a), the relevant regulations (P.27a-29a) or case law (*Sigety v. Ingraham*) that an individual facility could be denied reimbursement under the regulations as applied consistently until then by the Commissioner. Indeed, any such suggestion would have been contrary to the language of the later amended regulations and the intent of Article 4, Section 8, New York State Const. (P.16a). It would have contravened a long line of State decisions that regulations are binding on administrators until lawfully changed. *O'Brien v. Delaney*, 255 A.D. 385, 7 N.Y.S. 2d 596, *aff'd.*, 280 N.Y. 697, 21 N.E. 2d 202; *Walsh v. Planning Board of Eastchester*, 138 N.Y.S. 2d 362; *Jacoby v. McNamara*, 83 N.Y.S. 2d 763, *aff'd.*, 275 A.D. 695, N.Y.S. (870) 2d 431; *People ex rel. Jordan v. Martin*, 152 N.Y. 311, 46 N.E. 485. The promulgated regulations had the force of law, *People ex rel. Doscher v. Sisson*, 222 N.Y. 387, 118 N.E. 789; *Poss v. Kern*, 263 A.D. 320, 32 N.Y.S. 2d 979. "An administrative agency may not ignore a regulation of its own which has the full force of law." 1 N.Y. Jur. Section 109, p. 461.

While *Sigety v. Ingraham* suggested that the appellant therein would have had just cause to complain to perform a public service (take all Medicaid patients) below actual fixed costs, the Court of Appeals failed to provide relief when petitioner herein noted that it was in exactly such a position, so that its property rights were involved.

Respondents do not contest that they had always used the approved sales price as the basis of reimbursement and continue to do so with regard to all facilities which were acquired prior to the change in the regulations, with the one exception of petitioner. Nothing in 42 U.S.C. §1396, *et seq.*, or the Federal Medicaid regulations then or thereafter suggest that the provisions of the approved State Plan for Medicaid which detailed the reimbursement methodology, could be abandoned and different principles from a distinct Federal program (Medicare) applied retroactively to produce a different result. Where reservation of the right to change a rate computed in accordance with the regulations *is not* set forth in a Federal statute or regulation, or in any judicial interpretation of legislation, Federal case law has barred the action complained of. *Arizona Grocery Co. v. Atchison Topeka & Santa Fe Ry. Co.*, 248 U.S. 370; *F. Uri v. Bowles*, 152 F.2d 713 (9th Cir. 1964). As the Commissioner had uniformly acted by applying the federally approved regulations in this Federal grant-in-aid program, and using approved property cost incurred in a *bona fide*, arms-length, fully disclosed transaction as the basis of reimbursement, and since such interpretation is fully consistent with the published regulations, petitioner submits that the Commissioner was required according to both Federal and State law to use the purchase price approved by the Health Department. He had no statutory or regulatory authority to do otherwise.

2. Petitioner Had A Right To Rely On Past Practice

Respondents do not contest and apparently concede that the Commissioner departed only in this one instance, from his consistent practice of using approved cost as the basis for reimbursement in the rate. The record on appeal to the Court of Appeals sets forth two transactions preceding the instant matter, where *conditional* contracts as herein to transfer real property[3]

3. The contract of sale filed with the Department of Health herein specifically conditioned purchaser's obligation to buy on *approval* of the contract by the Department.

were disapproved by the Health Department determination that the sales price was too high. Thus, when the Health Department approved the transaction, petitioner had every right to anticipate that it would be reimbursed in accordance with the regulations and practice of the Department, as applied to all other facilities similarly situated.

Respondents argument that petitioner should have anticipated that Medicare principles of reimbursement would apply is totally specious. Even the State courts rejected this position. Petitioner had a right to anticipate that the Commissioner would apply reimbursement principles contained in the State Plan for Medicaid approved by the United States Department of Health, Education and Welfare, 42 U.S.C. §1396a as mandated, Art. VI, Cl. 2, U.S. Const.

3. Health Department Approval Did Bind The Commissioner

Respondents brief seeks to convey the impression that the Commissioner's first opportunity to avoid the reimbursement impact of the sale was at the time he was required to fix petitioner's Medicaid rate (R.4, 6, 8). The record to the Court of Appeals reflects the fact that the Commissioner through his responsible employees served as the staff of the Public Health Council. They joined in the approval of the proposed sale, and raised no objection that it would have an adverse impact on reimbursement. In fact, Public Health Law §§2801(1), (4), 2802(2) (P.19a-23a) required the Commissioner to participate in the decision whether or not to approve the transfer of the property. Had the Commissioner withheld his approval or objected to the transfer, the conditional sale would not have taken place. In disapproving reimbursement the Commissioner was acting contrary to his own approval.[4]

4. §2802(3)(d) requires the Commissioner to consider the "adequacy of financial resources and sources of future revenue." The full subdivision is set forth at page 1a of Appendix A.

Since the Commissioner had a statutory role in the approval of the proposed sale, independent of the Public Health Council, and his staff provided the recommendations upon which the Public Health Council acted, *United States v. R.C.A.* cited by respondent (R.9) is not relevant.

Matter of 225 E. 70th St. Corp. v. Weaver (R.9) is not relevant since petitioner has not received other compensation or benefits that would offset its fixed annual loss of $140,000 over the life of the mortgage.

B. AS TO RESPONDENTS' POINT II

Respondents urge that the "decisions of the courts below were supported by ample precedent and well within the requirements of the Federal Law." (R.10). For the reasons set forth above such is not the case. The action was unexpected and contrary to all precedent.

Respondents urge that the petitioner has failed to demonstrate any denial of rights protected by the Federal Constitution (R.10). This is not so. Petitioner submits that it has been denied due process of law, and equal treatment under the law.

Respondents' reliance on *Great Northern Ry. Co. v. Sunburst Oil & Refining Co.* (R.10) is misplaced. In *Great Northern* the State's highest court had overruled a prior decision which had permitted a shipper to recapture a common carrier's excessive charges. The question was whether the State Court's new interpretation of the statute must be given retroactive effect to relieve a carrier from burdens imposed by the State Court's erroneous prior interpretation of the statute. Justice Brandeis held that the Federal constitution did not mandate a retroactive application of the new ruling barring recapture, since the carrier and customer (like petitioner herein) had bargained under the preexisting interpretation of State Law. In distinguishing

Arizona Grocery Co. v. Atchison, the Court noted that the ICC rate in *Arizona* was not a provisional rate and accordingly the Federal statute did not permit a recapture of any excess charges. Similarly, the Federally approved State Plan covering reimbursement did not provide for provisional rates. The State Plan set forth specific State reimbursement regulations pursuant to which a *prospective* rate was to be calculated. There can be no serious contention that rates calculated in accordance with the Federally approved reimbursement methodology were to be provisional. The amended regulations two months after the sale took place and the petitioner's costs were fixed, were by their very terms to be applied to all transactions subsequent to the instant matter. While it is true that *Arizona* was disposed of through statutory interpretations, it is nevertheless clear from a reading of that case and *Great Northern* that a statute or regulation may not be given a retroactive application contrary to its terms to divest a person of substantial vested property rights.

Contrary to respondents' contention (R.11) nothing in *Sigety* or in any other judicial or statutory authority suggests that at the time of the approved sale, and the closing of title of June 29, 1971 the detailed reimbursement regulations 10 NYCRR §86 incorporated in the approved State Plan were an experiment entitling the Commissioner to withhold constitutionally an statutorily secured rights. While the Medicaid Act 42 U.S.C. §1396 *et seq.* authorized the State to develop a plan for reimbusement, it did not confer a license upon the State to refuse to follow its own Federally approved Plan and to breach fundamental protections secured by the United States Constitution. Moreover, it is manifestly unfair to take petitioner's property as suggested by respondents (R.11), because the State allegedly has chosen to "experiment".

C. RESPONDENTS' POINT III

Respondents apparently concede that petitioner was singled out for unique treatment (R.11), despite the fact that

respondents could have disapproved the proposed sale, as was their right, and as they had done in prior transactions. In such event there would not have been a closing. It is uncontested that petitioners' entire transaction was at arms-length, *bona fide* and fully disclosed. Surely, equity and justice require that the arbitrary taking of petitioners' property by respondents be rejected.

Respondents admit that the regulations which were applicable to the instant situation were changed by the respondents in August, 1971, a little over one month *after* the facility was purchased by the petitioners. Thus, respondents concede that the regulations in question 10 NYCRR §§86.21, 86.24, 86.29 and 86.32, were all mandated subsequent to the approval of the conditional contract by the Public Health Council on June 8, 1971 and the passage of title pursuant to the contract of sale on June 29, 1971.

Respondents demonstrate the weakness of its position by stressing the fact that petitioner alone has been singled out. Respondents urge on this Court that the particular facts of this case are not likely to recur. Petitioner submits that the unlawful and unconstitutional treatment accorded to it is a ground for granting the petition for certiorari and not a basis for denying such petition. It is to the courts that individual citizens must come for protection against the arbitrary action of the executive. Justice and fairness denied in any one case is a denial of justice and fairness to all of us.

Moreover, as has been stated by this Court again and again, the fact that the denial relates to property rather than the person is not a distinction which is not constitutionally protected. The implications of the determination of the New York State Court of Appeals (the Court apparently could not write an opinion) are that if a state can apparently choose to depart in a single instance from the rule of law and deny without advance notice reimbursement for fixed previously approved, long-term real

property costs under the Medicaid, or any other Federally approved Program, no investor or instituional lender can feel secure in putting his capital into a specialized project to carry out a public need. The singling out of any facility for such treatment will surely effect potential investors and lenders and result in a refusal of private new capital to meet the acknowledged health need. If the Medicaid Program is permitted to be a matter of "experimentation" as respondents urge, with principles of reimbursement subject to retroactive adjustments and the property rights of providers trampled upon, such a policy is properly a concern of the courts. If such a policy is in the public interest a potential investor should be warned in advance so that he may judge whether it is in his best interests to make a binding financial commitment to such a Program.

CONCLUSION

Petitioner submits that government is and must be limited by rules, regulations and policy which are applicable to all. Respondents are sworn to uphold the law. They may not ignore their own consistent method of procedure, and their own rules and regulations and apply to the unsuspecting statutory standards never applied before. It is significant that the Court of Appeals of the State of New York presented with all of the many issues, constitutional and otherwise, failed to write an opinion in this case. It was unable to do so. This Court should exercise the power to review such arbitrary and unconstitutional conduct by the executive and provide a forum to redress petitioners' grievances by granting the petition for certiorari.

Dated: New York New York
July 1, 1977

Respectfully submitted,

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APPENDIX A

§2802. Approval of construction

3. Subject to the provisions of paragraph (b) of subdivision two, the commissioner in approving the construction of a hospital shall take into consideration and be empowered to request information and advice as to (a) the availability of facilities or services such as preadmission, ambulatory or home care services which may serve as alternatives or substitutes for the whole or any part of the proposed hospital construction;

(b) the need for special equipment in view of existing utilization of comparable equipment at the time and place and under the circumstances proposed;

(c) the possible economies and improvements in service to be anticipated from the operation of joint central services including, but not limited to laboratory, research, radiology, pharmacy, laundry and purchasing; and

(d) the adequacy of financial resources and sources of future revenue.